

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EMINUSIA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>23X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daly</u> Middle <u>Adkins</u> Last <u>Adkins</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 17-1961</u>
9. AGE (In years last birthday) <u>2</u> yrs. <u>39</u> Min.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>39</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, MD</u>	
11. BIRTH PLACE (State or foreign country) <u>Salisbury, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Merrill Thomas Adkins</u>		14. MOTHER'S MAIDEN NAME <u>Edna E. McYall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>M. Thomas Adkins, Snow Hill, MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Maternal Antenatal Bleeding</u> (c) <u>Maternal Antenatal Bleeding</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> 19 <u>61</u> , to <u>1/17</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>61</u> , and that death occurred at <u>7:15</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>Alfred C. Kells</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried Jan 17/61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's Baptist Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Snow Hill, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Dennis</u>		25a. REC'D BY REGISTRAR <u>JAN 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		25c. DATE	

2042353XV2

1904

DATE

TIME

AGE

SEX

RACE

EDUCATION

RELIGION

INDUSTRY

RESIDENCE

1. Name of deceased  
2. Date of birth  
3. Place of birth  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Duration of illness  
8. Name of physician  
9. Name of attending nurse  
10. Name of undertaker  
11. Name of funeral home  
12. Name of cemetery  
13. Name of burial place  
14. Name of interment place  
15. Name of monument  
16. Name of grave  
17. Name of lot  
18. Name of section  
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Attest  
Registrar

Witness  
Anterior

1. Name of deceased  
2. Date of birth  
3. Place of birth  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Duration of illness  
8. Name of physician  
9. Name of attending nurse  
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VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1265  
CERTIFICATE OF DEATH  
01251

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1yr. 8mo. 23days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer s Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>R.</b> Last <b>Bozman</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>X-2</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Bell Bozman</b>		14. MOTHER'S MAIDEN NAME <b>Maley Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Brice Bozman, Oriole, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>332x</b> IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Arteriosclerosis general</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs.</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1959</b> to <b>Jan 28, 1961</b> , that (I) (we) lost saw the deceased alive on <b>Jan 28, 1961</b> , and that death occurred on <b>Jan 28, 1961</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>V. Juerman</b>		22b. DATE SIGNED <b>Jan 29, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1/31/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oriole</b>		23d. LOCATION (City, town, or county) (State) <b>Oriole, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Hanna</b>		25. REC'D BY REGISTRAR DATE <b>FEB 7 '61</b>	
ADDRESS <b>Princess Anne, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	





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VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1266

1252

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Georgia Brenner</b>		4. DATE OF DEATH <b>January 26 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-30-1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robe Kenna</b>		14. MOTHER'S MAIDEN NAME <b>Maetha Kenna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs Georgia Carter</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>Arteriosclerosis, general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>420.0</b> (b) <b>Arteriosclerosis, general</b> (c) <b>Arteriosclerosis, general</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Yrs</b> <b>Yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Old cerebral thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 12 1961</b> to <b>Jan. 26 1961</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>12:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>		22b. DATE SIGNED <b>1/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-29-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Perryhawkin Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Near Princess Anne, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>		25a. REC'D BY REGISTRAR <b>FEB 1 '61</b>	
ADDRESS <b>Princess Anne, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

21-75-1

or

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VR A15 (4)  
15M 9/59

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1267  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
01253

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>10 HOURS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Pocomoke City</u> d. STREET ADDRESS <u>R.F.D. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LUTHER</u> Middle <u>S.</u> Last <u>Brittingham</u>		4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 16, 1905</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES L. BRITTINGHAM</u>		14. MOTHER'S MAIDEN NAME <u>EMMA R. RITCHIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW #2</u>		16. SOCIAL SECURITY NO. <u>215-16-8394</u>	
17. INFORMANT <u>MRS CLARENCE J. TAYLOR, Pocomoke City, MD.</u>		Address <u>R.F.D. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> 19 <u>61</u> , to <u>1-10</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-10</u> 19 <u>61</u> , and that death occurred at <u>Salisbury</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. R. Ellis, Jr.</u>		22b. DATE SIGNED <u>1-10-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. R. ELLIS, JR. M.D.</u>		22d. ADDRESS <u>SALISBURY, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-13-61</u>	
23c. NAME OF CEMETERY <u>GOODWILL METHODIST</u>		23d. LOCATION (City, town, or county) <u>RURAL - Pocomoke City MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>		25a. REC'D BY REGISTRAR <u>JAN 16 '61</u>	
ADDRESS <u>Pocomoke City, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>	



1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1268  
CERTIFICATE OF DEATH

61254

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 Union Road</b>		d. STREET ADDRESS <b>R.D.# 1 (Union Rd)</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SYDNEY</b> Middle <b>TULL</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>10th</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1869</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Anthony Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Malone</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs. Iris B. Long (Daughter)</b>		Address <b>R.D.# 1 Union Rd Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442x</b> IMMEDIATE CAUSE (a) <b>Cardiovascular renal disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>19 58 to 1-10</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1-9</b> 19 <b>61</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Philip A. Insley</b>		22b. DATE <b>January 11/1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>		22d. ADDRESS <b>Main St. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 14, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery-R.D.# 1 (Union Rd) Salisbury, Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>JAN 13 '61</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Huns</b>	

WESTLAND RATE DEPARTMENT OF HEALTH  
CERTIFICATE OF CHAIN

1208

WESTLAND RATE DEPARTMENT OF HEALTH  
CERTIFICATE OF CHAIN  
No. 1208  
Date of Issue: 10/10/1910  
Name of Person: J. J. J. J. J.  
Address: 10/10/1910  
Signature: J. J. J. J. J.  
Official Seal: J. J. J. J. J.

WESTLAND RATE DEPARTMENT OF HEALTH

WESTLAND RATE DEPARTMENT OF HEALTH  
CERTIFICATE OF CHAIN  
No. 1208  
Date of Issue: 10/10/1910  
Name of Person: J. J. J. J. J.  
Address: 10/10/1910  
Signature: J. J. J. J. J.  
Official Seal: J. J. J. J. J.



1 **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1269 **CERTIFICATE OF DEATH** 61255

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>R.D.# 1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>NORMAN</b> Middle <b>LEE</b> Last <b>BRUMLEY</b>		<b>4. DATE OF DEATH</b> Month <b>JANUARY</b> Day <b>5th</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>March 19, 1908</b>
<b>9. AGE</b> (In years last birthday) <b>52</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Employed (J.H. Dulany Foods Inc) Supv.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Eden, Maryland</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>U S A</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Glenmore Franklin Brumley</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Carey</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Mrs. Lucille G. Brumley (Wife) R.D.#1</b> <b>Hebron, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>163 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma left lung</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		<b>20f. (City or town)</b> <b>N/A</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>10/8/54</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>1/5/61</b> , and that death occurred at <b>12:30 P.M.</b> <b>1/5/61</b> 19, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Andrew C. Mitchell</b>		<b>22b. DATE SIGNED</b> <b>Jan. 6 /1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Andrew C. Mitchell</b>		<b>22d. ADDRESS</b> <b>Maryland Ave. Salisbury, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Jan. 8, 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Salisbury, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 9 '61</b>	
<b>ADDRESS</b> <b>SALISBURY MARYLAND</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur E. Hume</b>	

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VS. A15ME  
5M 7/59

## 1270 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

YLAND 250

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>16 Newport Acree</b>	
3. NAME OF DECEASED (Type or print) <b>Michael Bryant</b>		4. DATE OF DEATH <b>1-26-61</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-8-1958</b>	
9. AGE (In years last birthday) <b>2 1/2</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>_____</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>_____</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Calvin Barckley</b>		14. MOTHER'S MAIDEN NAME <b>Doris Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <b>_____</b>		16. SOCIAL SECURITY NO. <b>_____</b>	
17. INFORMANT <b>Doris Williams, Salisbury, Md.</b>		Address <b>16 Newport Acree</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningococcemia</b> <b>057.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>_____</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>		20f. (City or town) (County) (State) <b>Salisbury Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		DATE SIGNED <b>1-27-61</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-29-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GREEN ACRES CEM</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury Md.</b>	
23. FUNERAL DIRECTOR <b>Thornton B. Walley, Salisbury, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 31 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

FOR STATE  
DEPT. OF HEALTH

1970

MARTIN LUTHER KING, JR.  
MARTIN LUTHER KING, JR.  
MARTIN LUTHER KING, JR.

Memphis

Memphis

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1271  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
01257

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>330 Camden Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>John Thomas Burkhardt</u> First Middle Last				4. DATE OF DEATH <u>January 10 1961</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR <u>3</u> Months <u>25</u> Days		IF UNDER 24 HRS. <u>3</u> Hours <u>25</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee (Wico. Hotel)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Interior Decorator- Baltimore Co. Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U S A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Charles Burkhardt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth (No Record)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>163X</u>			
17. INFORMANT <u>Mrs. Estelle M. Burkhardt (Wife)</u> Address <u>330 Camden Ave. Salisbury, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epidermoid CA of Lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>N/A</u> 19 p. m. <u>N/A</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>				20f. (City or town) <u>N/A</u> (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>Jan 10 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 9 1961</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Gray</u> M.D.				22b. DATE <u>Jan. 10, 1961</u> SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>				22d. ADDRESS <u>Camden Ave. Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 12, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL MEMORY GARDENS-</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JAN 13 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

DEPARTMENT OF HEALTH AND STATE  
OFFICE OF THE ATTORNEY GENERAL  
STATE OF CALIFORNIA



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)  
15M 9/59

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1272

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

61258

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Quantico</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.#</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>GREENSBURY</b> Last <b>BYRD</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>17th</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>14</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>R.D.# Quantico, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Joseph Francis Byrd</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Owens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Lee C. Byrd (Son)</b>		Address <b>R.D.# Quantico, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subacute cytophyelonephritis</b> DUE TO <b>610 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertrophy of prostate gland</b> DUE TO <b>with urine retention</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>3 years?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic encephalopathy and coronary</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 <b></b> p. m. <b></b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4:05 A.</b> to <b>Jan 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 10, 1961</b> , and that death occurred at <b>4:05 A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L.V. Sohler</b>		22b. DATE SIGNED <b>Jan. 19, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>		22d. ADDRESS <b>Delmar, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 19, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMTERY</b>		23d. LOCATION (City, town, or county) (State) <b>SALISBURY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>JAN 23 61</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Carroll S. Thayer</b>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

1272

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF MINISTER

NAME OF CLERGYMAN

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1273  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02460

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 20 da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Quantico</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>Naomi</b> Last <b>Camper</b>		4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/2/1906</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>11</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ass't Dietian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Perry Wright</b>		14. MOTHER'S MAIDEN NAME <b>Sarah J. Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>David Camper, Quantico, Md RT #1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breasts w/metastases to Chest</b> DUE TO <b>170 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/12/60</b> 19 to <b>1/31/61</b> 19, that (I) (we) last saw the deceased alive on <b>1/31/61</b> 19, and that death occurred at <b>5: M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>V. Juerman</b>		22b. DATE SIGNED <b>15P.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>		22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Weptquin, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 8 '61</b>	
ADDRESS <b>Salisbury, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

1937

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of birth: Jan 15 1892

5. Place of birth: New York City

6. Usual residence: 123 Main St, New York City

7. Cause of death: Heart Disease

8. Date of death: Dec 10 1937

9. Time of death: 10:30 AM

10. Place of death: Home

11. Signature of attending physician: Dr. J. Smith

12. Signature of registrar: John Doe

13. Signature of informant: John Doe

14. Name of informant: John Doe

15. Address of informant: 123 Main St, New York City

16. Signature of medical examiner: Dr. J. Smith

17. Signature of coroner: John Doe

18. Signature of undertaker: John Doe

19. Signature of funeral home: John Doe

20. Signature of cemetery: John Doe

1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1274  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
C1259

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 WKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>1 Johnson Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>ANN</u> Last <u>Chatham</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 2, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alec B. Malone</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>C. HERBERT CHATHAM, SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443 X</u> DUE TO (b) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u>Hypertensive C.V. Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>17 days</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> 19 <u>  </u> to <u>11 Jan</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11 Jan 1961</u> , and that death occurred on <u>12 Jan</u> 19 <u>61</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Earl A. Royer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl A. Royer</u>				22d. ADDRESS <u>407 Camden Ave Sal. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-13-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co.</u>				ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 16 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

King C. Peel





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1260

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>12 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b> d. STREET ADDRESS <b>814 Second St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rena Mae Taylor Choquette</b>		4. DATE OF DEATH Month Day Year <b>1-30-61 19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1927</b>
9. AGE (In years last birthday) <b>33 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>33</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arie James Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Bailey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>218-20-7766</b>	
17. INFORMANT <b>Mrs Arie J. Taylor, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia: Peritonitis.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bullet wounds of left chest &amp; abdomen</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by R. L. Parker</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>11:30 P.M. 1-17-61</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Pocomoke Worcester Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2-1-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-2-61</b>	
22c. NAME OF CEMETERY OR BURIAL PLACE <b>First Baptist</b>		22d. LOCATION (City, town, or country) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR <b>Henry S. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1276

Item 14 Film 281 2-14-61 et

1261

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b> <b>23X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PEN. GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>Bay St</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS CORNELIUS Coffin</b>		4. DATE OF DEATH Month Day Year <b>JAN. 31 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN BUSINESS</b>	
11. BIRTHPLACE (State or foreign country) <b>BERLIN, MD (RFD)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS T. COFFIN</b>		14. MOTHER'S MAIDEN NAME <b>Cora Trader</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Atherosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Urinary Tract infection.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-16-61</b> to <b>1-31-61</b> that (I) (we) last saw the deceased alive on <b>31-19-61</b> and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert Thomas</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Thomas</b>		22d. ADDRESS <b>Pennsville General Hosp</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/3/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>TAYCOCKVILLE</b>		23d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burdette</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
ADDRESS <b>Berlin Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 6 '61</b>	

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082

1918

1. Name of deceased Thomas T. Coffin  
2. Sex Male  
3. Age 34  
4. Date of birth Nov. 11, 1883  
5. Place of birth Pen. Prison - Harrison, N. J.  
6. Usual residence Thomas C. Coffin, 1010 14th St. N. W., Wash. D. C.  
7. Cause of death Scarlet Fever  
8. Date of death Nov. 11, 1918  
9. Place of death Home  
10. Signature of attending physician Wm. H. Coffin  
11. Signature of medical examiner Wm. H. Coffin  
12. Signature of coroner Wm. H. Coffin  
13. Signature of registrar Wm. H. Coffin  
14. Signature of undertaker Wm. H. Coffin  
15. Signature of funeral home Wm. H. Coffin  
16. Signature of cemetery Wm. H. Coffin  
17. Signature of interment Wm. H. Coffin  
18. Signature of burial Wm. H. Coffin  
19. Signature of cremation Wm. H. Coffin  
20. Signature of other Wm. H. Coffin

21. Name of funeral home Wm. H. Coffin  
22. Name of cemetery Wm. H. Coffin  
23. Name of interment Wm. H. Coffin  
24. Name of burial Wm. H. Coffin  
25. Name of cremation Wm. H. Coffin  
26. Name of other Wm. H. Coffin  
27. Name of funeral home Wm. H. Coffin  
28. Name of cemetery Wm. H. Coffin  
29. Name of interment Wm. H. Coffin  
30. Name of burial Wm. H. Coffin  
31. Name of cremation Wm. H. Coffin  
32. Name of other Wm. H. Coffin

33. Name of funeral home Wm. H. Coffin  
34. Name of cemetery Wm. H. Coffin  
35. Name of interment Wm. H. Coffin  
36. Name of burial Wm. H. Coffin  
37. Name of cremation Wm. H. Coffin  
38. Name of other Wm. H. Coffin  
39. Name of funeral home Wm. H. Coffin  
40. Name of cemetery Wm. H. Coffin  
41. Name of interment Wm. H. Coffin  
42. Name of burial Wm. H. Coffin  
43. Name of cremation Wm. H. Coffin  
44. Name of other Wm. H. Coffin

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1277

1262

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague, Virginia</u> 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>102 Ocean Blvd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lydia MAE Collins</u>				4. DATE OF DEATH Month Day Year <u>1 29 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 9 1900</u>	
9. AGE (In years last birthday) yrs. <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Chincoteague</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Pointer</u>		14. MOTHER'S MAIDEN NAME <u>Dora Wimbrow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Harry Collins Jr. Chincoteague, Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pneumococcal Meningitis</u> DUE TO <u>340.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/29 1961</u> to <u>1/29 1961</u> , that (I) (we) last saw the deceased alive on <u>1/29 1961</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Schwane</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SANCTIFIED Church Cem PERRY GA.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Selpe, Chincoteague, Va.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	





1278

1263

MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/60

1231

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 1264

1279

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. # 1</u>				d. STREET ADDRESS <u>R.F.D. # 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Phoebe</u> Middle <u>E.</u> Last <u>Cottman</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1863</u>	9. AGE (In years last birthday) <u>97</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Cathell</u>				14. MOTHER'S MAIDEN NAME <u>Jane Cathell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arterio Sclerosis Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>15 Dec 60</u> to <u>4 Jan 61</u> that I last saw the deceased alive on <u>4 Jan 61</u> , and that death occurred at <u>5 P M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				DATE SIGNED <u>1/5/61</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quantico</u>		22d. LOCATION (City, town, or county) <u>Quantico Md</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart Salisbury Md</u> ADDRESS <u>  </u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1280

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01265

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Laurel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Culver</u>		4. DATE OF DEATH January 9 1961	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1961</u>
9. AGE (In years last birthday) <u>1</u> yrs. <u>1</u> month <u>1</u> day <u>1</u> hour <u>1</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Culver</u>		14. MOTHER'S MAIDEN NAME <u>Doris Hitch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert Culver, Laurel, Del.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 650 gms)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>approx 2 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> 19 <u>61</u> to <u>1/9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> 19 <u>61</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred C. Koles</u>		22b. DATE SIGNED <u>1/10/61</u>	
22c. PHYSICIAN'S NAME (Type) _____		22d. ADDRESS <u>Medical Center Salisbury Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Laurel Del</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>THARREY WILLIAMSON</u>		25a. REC'D BY REGISTRAR <u>JAN 13 '61</u>	
ADDRESS <u>FEDERALSBURG MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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CENTRAL CASE OF DEATH

1920



Doc.  
Hansen

Jan 1 1921

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1281

1268

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>116 E. Locust St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>DAVIS</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 12, 1906</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver (Operator)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Joseph Davis</b>				14. MOTHER'S MAIDEN NAME <b>Clara Webster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Gladys P. Davis (Wife)</b> Address <b>116 E. Locust St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct, acute</b> <b>420.1</b> DUE TO (b) <b>6 hours</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1/26 1961</b> to <b>1/26 1961</b> , that (I) (we) last saw the deceased alive on <b>1/26 1961</b> , and that death occurred at <b>11:00 P. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wilber R. Ellis Jr.</b>				22b. DATE SIGNED <b>Jan. 30/1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Wilber R. Ellis Jr</b>	
22d. ADDRESS <b>Medical Center Salisbury, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 29, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>				25a. REC'D BY REGISTRAR <b>JAN 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1981

1

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Date of birth: \_\_\_\_\_

4. Date of death: \_\_\_\_\_

5. Place of death: \_\_\_\_\_

6. Cause of death: \_\_\_\_\_

7. Signature of physician: \_\_\_\_\_

8. Signature of registrar: \_\_\_\_\_

9. Date of registration: \_\_\_\_\_

10. Place of registration: \_\_\_\_\_

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1282

01207

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>X</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.D.# 3 Mt. Hermon Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>THOMAS</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1892</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee-City Bus Co.(Driver)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Wicomico Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>James Thomas Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kelley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Virgie E. Davis (Wife)</u> Address <u>R.D.# 3 Mt Hermon Road Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary artery occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary artery sclerosis</u> DUE TO (c) <u>gen. arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>ser. yew.</u> <u>" "</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <u>N/A</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 23, 1954</u> to <u>Jan 17, 1961</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>Jan 17, 1961</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Harry Mattax</u>				22b. DATE SIGNED <u>1/17/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Harry Mattax</u>	
22d. ADDRESS <u>Camden Ave. Salisbury, Maryland</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 20, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				25a. REC'D BY REGISTRAR <u>SALISBURY MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>DATE JAN 19 '61</u>	

CERTIFICATE OF DEATH

1282

DATE OF DEATH  
PLACE OF DEATH

AGE  
SEX

CAUSE OF DEATH  
MANNER OF DEATH

DATE OF BIRTH  
PLACE OF BIRTH

EDUCATION  
OCCUPATION

RELIGION  
MARRIAGE

PREVIOUS ILLNESS  
PREVIOUS SURGERY

PREVIOUS TRAUMA  
PREVIOUS DRUGS

PREVIOUS ALCOHOL  
PREVIOUS TOBACCO

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1283

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1268

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>BRIDGE ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>GLENN E ELLIOTT</u>				4. DATE OF DEATH <u>JANUARY 26, 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 20, 1899</u>	
9. AGE (In years lost/birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-14-982</u>		17. INFORMANT <u>MRS LUCY ELLIOTT</u> Address <u>MARDELA. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> 19 <u>61</u> to <u>1-26</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-26</u> 19 <u>61</u> , and that death occurred at <u>1-26</u> 19 <u>61</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilbur R. Elliott</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>1-26-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILBUR R ELLIOTT JR</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 29, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MARDELA</u>		23d. LOCATION (City, town, or county) (State) <u>MARDELA. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SMITH FUNERAL HOME SHARPTOWN</u> ADDRESS				25a. REC'D BY REGISTRAR <u>FEB 1 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Curtis L. Thomas</u>	

CERTIFICATE OF DEATH

1933

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be expected within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1284  
CERTIFICATE OF DEATH

1269

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ferry Street</b>				d. STREET ADDRESS <b>205 Record St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDGAR SLEMONS ELLIS</b>				4. DATE OF DEATH Month Day Year <b>JAN. 1st 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 20, 1883</b>	
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>11</b>		11. IF UNDER 24 HRS. Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railroad Employee</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Delmar, Delaware</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Monroe W. Ellis</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Morris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>				16. SOCIAL SECURITY NO. <b>Unk</b>			
17. INFORMANT <b>Mrs. J. Edwin Windsor (Daughter)</b>				Address <b>Ferry St Sharptown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident - Hemiplegy</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-vascular Dis.</b> DUE TO (c) <b>Arteriosclerosis, generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immed</b> <b>10 yrs</b> <b>20 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 p. m. <b>N/A</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>14 Dec 1960 to 1 Jan 1961</b> , that (I) (we) last saw the deceased alive on <b>31 Dec 1960</b> , and that death occurred at <b>10:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George G. Schlesinger M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan. 2 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. George G. Schlesinger</b>				22d. ADDRESS <b>Mardela, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 5, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Delmar, Delaware</b>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

1285

C1270

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>700 West St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>A.</u> Last <u>ERDMAN</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 15, 1877</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>		IF UNDER 24 HRS. Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John ERDMAN</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bamberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>221-07-0124</u>		17. INFORMANT Address <u>ELLA E. Windsor. Laurel. Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>420.0</u> DUE TO <u>antecedent heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> DUE TO <u>antecedent heart disease</u> lying cause lost. (c) <u>antecedent heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Postoperative prostatic</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13, 1961</u> to <u>Jan 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 13, 1961</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond M. Yan</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.P.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/14/61</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem</u>	
23d. LOCATION (City, town, or county) (State) <u>Laurel, Del.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. HARVEY WILLIAMSON, FEDERALSBURY, MD.</u>				25a. REC'D BY REGISTRAR <u>JAN 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

CERTIFICATE OF DEATH

1988

10/10/1988

~FELIX~

10/10/1988

ROBERT

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WHITE

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John Edward

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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1286 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61271

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> ✓		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pen Gen Hospital</b>			e. STREET ADDRESS <b>206 Glen Ave.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>BEATRICE ELEANOR EVANS</b>			4. DATE OF DEATH Month <b>January</b> Day <b>8th</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1876</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>William J. Brown</b>		
14. MOTHER'S MAIDEN NAME <b>Cordela McAllen</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>1</b>			17. INFORMANT <b>Mr. Lawrence L. Pusey Jr. (Nephew)</b> Address <b>3233 Hanover Ave. Richmond 21, Virginia</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Edema</b> <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Fracture 5th Dorsal Vertebra</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>5 hours</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down stairs at home</b>		
20c. TIME OF INJURY Month, Day, Year <b>11</b> Hour <b>6 a.m.</b> <b>1.8.61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Salisbury</b>	(County) <b>Wicomico</b>	(State) <b>MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>January 11 / 1961</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 11, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian Church Cem.</b>	22d. LOCATION (City, town, or country) <b>Princess Anne, Md.</b>	(State) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>			ADDRESS <b>SALISBURY MARYLAND</b>		
24a. REC'D BY REGISTRAR <b>JAN 13 '61</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		

1988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Date of Birth: \_\_\_\_\_

4. Date of Death: \_\_\_\_\_

5. Place of Death: \_\_\_\_\_

6. Cause of Death: \_\_\_\_\_

7. Manner of Death: \_\_\_\_\_

8. Signature of Medical Examiner: \_\_\_\_\_

9. Signature of Coroner: \_\_\_\_\_

10. Signature of Registrar: \_\_\_\_\_



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1287

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1272

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA General Hospital</i>				d. STREET ADDRESS <i>430 Priscilla St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BERTHA</i> Middle <i>LEE</i> Last <i>FARLOW</i>				4. DATE OF DEATH Month <i>January</i> Day <i>3</i> Year <i>1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1890</i>		9. AGE (In years last birthday) <i>70</i> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Employee (Phillips Cleaners)</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>R.D.# Powellville, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>John Holland</i>				14. MOTHER'S MAIDEN NAME <i>Georgia A. Parker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. William E. Farlow (Son)</i> Address <i>430 Priscilla St Salisbury, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>P</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>previous Coronary Thrombosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>N/A</i> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>N/A</i>		20f. (City or town) (County) (State) <i>N/A</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 3 1961</i> to <i>Jan 3 1961</i> , that (I) (we) last saw the deceased alive on <i>Jan 3 1961</i> , and that death occurred at <i>3:50 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Dr. Earl M. Beardsley</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Jan. 3, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. Earl M. Beardsley</i>				22d. ADDRESS <i>Maryland Ave. Salisbury, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 6, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Charity Church Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>R.D.# Salisbury, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY &amp; COMPANY</i>				ADDRESS <i>SALISBURY MARYLAND</i>		25a. REC'D BY REGISTRAR <i>DATE JAN 5 '61</i>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1288

CERTIFICATE OF DEATH

Item 3 Film 6280 2-6-61 et

61273

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>111 Elizabeth St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Werner</b> First <b>THOMAS</b> Middle <b>GARDNER</b> Last		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1880</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-SERVICE TRUCKING CO.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accomac Co. Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Eva Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Sarah P. Gardner (Wife)</b> Address <b>111 Elizabeth St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pyloric stenosis</b> DUE TO (c) <b>Chyl. Pyl. ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>yrs</b> <b>1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>N/A 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>N/A</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1:27</b> to <b>1:30</b> , that (I) (we) last saw the deceased alive on <b>1:30</b> 1961, and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Henry A. Briele</b>		22b. DATE SIGNED <b>Jan 31 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Henry A. Briele</b>		22d. ADDRESS <b>Medical Center Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 2, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 2 '61</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARDIAN STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1289  
CERTIFICATE OF DEATH

61274

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>				c. LENGTH OF STAY IN 1b <b>App: 5yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Shade Nursing Home</b>				d. STREET ADDRESS <b>1 430 E. Church St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>VIRGINIA</b> Middle <b>B.</b> Last <b>GORDY</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>14th</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 30, 1872</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work - Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Lemuel Evans</b>				14. MOTHER'S MAIDEN NAME <b>Hester Hickman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b></b>			
17. INFORMANT <b>Mrs. Edna Brittingham</b> Address <b>Berlin, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Virus - Pneumonia</b> 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 <b></b> p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>				20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>			
21. I certify that (I) (this hospital) attended the deceased from <b>1/4 7:10 A.M. to Jan 14 1961</b> , that (I) (we) last saw the deceased alive on <b>1/13 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. H. S. Kuhlman</b>				22b. DATE SIGNED <b>Jan. 16 / 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. S. Kuhlman</b>				22d. ADDRESS <b>Sharptown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 16, 1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>				23d. LOCATION (City, town, or county) <b>SALISBURY, MARYLAND</b> (State) <b></b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>				25a. REC'D BY REGISTRAR <b></b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			
DATE <b>JAN 18 '61</b>							

CHIEF OF BUREAU

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1939

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1290

1275

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Delmar (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>R.D.# 3</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>JACKSON</b> Last <b>GULLY</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25th</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1895</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>27</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter-House Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Miss.</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unk</b>		14. MOTHER'S MAIDEN NAME <b>MMK Sarah - - - - -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Dorothy B. Gully (Wife)</b>		Address <b>R.D.#3 Delmar, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma in Melanotic</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic Carcinoma</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>August 1959</b> to <b>25 Jan 1961</b> , that (I) (we) last saw the deceased alive on <b>25 Jan 1961</b> , and that death occurred at <b>1:10 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph C. Fitzgerald</b>		22b. DATE SIGNED <b>Jan. 27 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph Fitzgerald</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Jan. 27 / 1961</b>		23b. DATE THEREOF <b>Jan. 27 / 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>JAN 31 '61</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CERTIFICATE OF DEATH

1200

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1291

1276

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1291

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>1410 PINE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER A. HALL</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 11, 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1892</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEMUEL HALL</u>		14. MOTHER'S MAIDEN NAME <u>LIZZIE BAILEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HETTIE HALL-DELMAR</u> MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>501X</u> DUE TO <u>Cox. Pulmonary, Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchitis &amp; Bronchial Asthma</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 11, 1961</u> to <u>January 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 11, 1961</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Sitone</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-14-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		23d. LOCATION (City, town, or county) (State) <u>DELMAR - DE</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marnel Co - Delmar, Del.</u>		25a. REC'D BY REGISTRAR <u>JAN 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>G. S. Hines</u>			

1931

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Place of death: \_\_\_\_\_

9. Signature of physician: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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1292

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

61277

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>40 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chestnut Stt.</b>		d. STREET ADDRESS <b>Chestnut St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Ellison</b> Middle <b>Rue</b> Last <b>Hastings</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1883</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wood</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Archillius Hastings</b>		14. MOTHER'S MAIDEN NAME <b>Martha Rue</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ida Hastings, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> <b>420.1</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Coronary arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis generalized</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 27 1961</b> to <b>Jan 28 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 27 1961</b> , and that death occurred at <b>2:30</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>L. V. Sohler</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>		22b. DATE SIGNED <b>1-30-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-30-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Grand Co - Delmar, Del.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 31 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Fenn</b>			

MINISTRY OF HEALTH  
STATEMENT OF DEATH

1902

Name of Deceased		Age		Sex	
Place of Birth		Date of Birth		Date of Death	
Cause of Death		Duration of Illness		Place of Death	
Signature of Doctor		Signature of Registrar		Signature of Witness	
Date of Statement		Time of Statement		Place of Statement	



may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1293

Item 8 Film 279 1-27-61 et

01278

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>			
c. LENGTH OF STAY IN 1b <u>6 Weeks</u>				d. STREET ADDRESS <u>GROVE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>HASTINGS</u> Last <u>HASTINGS</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1891</u> <u>9-30-1899</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>HOWARD SLACUM</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE HURLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>221-09-4887</u>		17. INFORMANT <u>Francis Waller - Delmar Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uterine</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Adenocarcinoma Uterus</u> (c) <u>9 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>50</u> to <u>Jan 22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 22</u> 19 <u>61</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John M. Bloxom III</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM III</u>				22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-24-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Cambridge, Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar, Del</u> ADDRESS				25a. REC'D BY REGISTRAR <u>JAN 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

STATEMENT OF DEATH

1283

Blank form with horizontal lines for text entry.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1294

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01279

1. PLACE OF DEATH o. COUNTY <b>WICOMICO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b <b>8 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DEER'S HEAD STATE HOSP.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>	
3. NAME OF DECEASED (Type or print) First <b>ETTA</b> Middle <b>MARY</b> Last <b>HENRY</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/20/1864</b>
9. AGE (In years lost birthday) <b>96</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD HENRY</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>MR. JOHN CLARK R.F.D.#1, CAMBRIDGE, MARYLAND.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</b> DUE TO (c) <b>ARTERIOSCLEROSIS GENERAL</b> INTERVAL BETWEEN ONSET AND DEATH <b>3d. Years</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4.11</b> <b>1960</b> to <b>1.6</b> <b>1961</b> , that (I) (we) lost the deceased alive on <b>1.6</b> <b>1961</b> , and that death occurred at <b>5:15</b> <b>P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>V. Guerman</b>		22b. DATE SIGNED <b>22b. DATE SIGNED</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/8/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>		25. REC'D BY REGISTRAR <b>DATE JAN 10 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

© 1917-1918

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1295

1280

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hillman Daniel Hopkins Jr.</u>				4. DATE OF DEATH Month Day Year <u>January 12, 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 13, 1923</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUS DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trailway Bus</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hillman D. Hopkins Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Janie Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Barbara A. Hopkins - Chincoteague, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion with Myocardial Infarction</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 27, 1960</u> to <u>Jan 12, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 12, 1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/12/61</u>	
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 15, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Red men Cemetery</u>		23d. LOCATION (City, town, or county) <u>Chincoteague, Va.</u> (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Selyer</u> ADDRESS <u>Chincoteague, Va.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1935

NAME OF DECEASED  
RESIDENCE  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
AGE AT DEATH  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS



TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

1  
1296  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

61281

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>26 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura Ellen Horsman</u>		4. DATE OF DEATH Month Day Year <u>Jan. 17 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Beechman Harrington</u>		14. MOTHER'S MAIDEN NAME <u>Delia Dunn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Lloyd Horsman</u>		Address <u>Bivalve, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>-</u> DUE TO <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus. Fractured Hip.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Fell w/ Hammer Fractured hip.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>8</u> p. m. <u>12 Dec. 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12 Dec. 1960</u> to <u>17 Dec. 1961</u> , that (I) (we) last saw the deceased alive on <u>17 Dec. 1961</u> and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Saunders</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. SAUNDERS M.D.</u>		22d. ADDRESS <u>NANTICOKE MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cern.</u>		23d. LOCATION (City, town, or county) (State) <u>Bivalve, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messersmith</u>		24b. ADDRESS <u>Bivalve, Md.</u>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>JAN 23 '61</u>			

1906

CERTIFICATE OF DEATH

1881



1297

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11262

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CARLTON</u> Middle <u>PERCY</u> Last <u>HOWARD</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16, 1893</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. UNDER 1 YEAR Months <u>67</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Wico. County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <u>House Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>			
13. FATHER'S NAME <u>Granville R. Howard</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>				16. SOCIAL SECURITY NO. <u>Unk</u>			
17. INFORMANT <u>Mrs. Hazel F. Howard (Wife)</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown thrombosis</u> DUE TO <u>Cholecystectomy (this morning)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>586X</u> (b) <u>Cholecystectomy (this morning)</u> (c) <u>Cholecystectomy (this morning)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> 19 <u>61</u> p. m. <u>N/A</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>				20f. (City or town) <u>N/A</u> (County) <u>N/A</u> (State) <u>N/A</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1-23</u> 19 <u>61</u> , to <u>1-30</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-30</u> 19 <u>61</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William H. Fisher</u>				22b. DATE SIGNED <u>Jan. 30, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>William H. Fisher</u>				22d. ADDRESS <u>Medical Center</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb. 3, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>				23d. LOCATION (City, town, or county) <u>Hebron, Maryland</u> (State) <u>Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 2 '61</u>			
ADDRESS <u>SALISBURY MARYLAND</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneave</u>			

1237

George Thompson  
(The Liberator)

March 11, 1848

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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082

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1283											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John Wesley Hudson</b>						4. DATE OF DEATH <b>1-6-61</b> 19 <b>61</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct-9-1918</b>		9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR: Months <b>1</b> Days <b>6</b> IF UNDER 24 HRS.: Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lebor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>				11. BIRTHPLACE (State or foreign country) <b>Wicomico</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hudson Sr</b>						14. MOTHER'S MAIDEN NAME <b>Vergie Dasset</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>WWII</b> (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. <b>214-1060300</b>					
17. INFORMANT <b>Dorothy Hudson</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (b) <b>491X</b> (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1-10-61</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres Cem Salisbury Md.</b>			
23. FUNERAL DIRECTOR <b>Booker McWest</b>				ADDRESS				24a. REC'D BY REGISTRAR <b>1-16-61</b>			
								24b. REGISTRAR'S SIGNATURE <b>Carlton L. Harris</b>			





61284

## Reg. Dist. No.

1299

MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/5B

CERTIFICATE OF DEATH

1929

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

TIME OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

NAME OF DECEASED

NAME OF FATHER

NAME OF MOTHER

NAME OF SPOUSE

NAME OF NEXT OF KIN

NAME OF PHYSICIAN

NAME OF BURIAL PLACE

NAME OF MINISTER

NAME OF REGISTRAR

NAME OF WITNESS

NAME OF CLERK

NAME OF JURY

NAME OF JURY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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1300  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
C1285

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>580 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>101 Fairmount Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bettie</b> Middle <b>Lula</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1896</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b>	IF UNDER 24 HRS. Hours <b>64</b> Min. <b>64</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (Country & State, or foreign country) <b>Talladega, Ala.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Anthony Parson</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Parson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rev. John English, Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus with gangrene of right foot</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		22. TIME OF INJURY Month, Day, Year <b>19</b> Hour e.m. <b>19</b> p.m. <b>19</b>	
23. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <b>Cambridge</b> (County) <b>Salisbury</b> (State) <b>Md.</b>	
25. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1959</b> , to <b>Jan. 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan. 31, 1961</b> , and that death occurred at <b>8:05 A.M.</b> from the causes and on the date stated above.			
26. SIGNATURE <b>V. Juerman</b>		27. DATE <b>1/31/61</b>	
28. PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		29. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>	
30. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		31. DATE THEREOF <b>2/5/1961</b>	
32. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>		33. LOCATION (City, town or county) <b>Cambridge, Md.</b>	
34. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert S. Sells</b>		35. ADDRESS <b>Cambridge, Md.</b>	
36. REC'D BY REGISTRAR <b>FEB 3 '61</b>		37. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1508

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Library

20 days

Continued

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North Main Street

Article

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January 1950

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Janis Larson

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Philadelphia, Pa.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1301  
CERTIFICATE OF DEATH

61286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b <u>8 mos</u>		d. STREET ADDRESS <u>657 Fitzwater St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>657 Fitzwater St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Colon</u> Middle <u>G.</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1960</u>
9. AGE (In years lost birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Colon G. White</u>	
14. MOTHER'S MAIDEN NAME <u>Janice Neal</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	
16. SOCIAL SECURITY NO. <u></u>		INFORMANT <u>Miss Janice Neal</u> Address <u>Salisbury, Md</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastroenteritis</u> 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 Jan 1961</u> to <u>7 Jan 1961</u> , that I last saw the deceased alive on <u>7 Jan 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. A. Purcell</u>		ADDRESS (Street, city or town, state) <u>652 W. main Salisbury, Md</u> DATE SIGNED <u>13 Jan 61</u>	
PHYSICIAN'S NAME (Type) <u>E. A. Purcell, M.D.</u>		M.D. <u>652 W. main Salisbury, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-10-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRE Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

2082182XV4





1302 **MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH** 01287

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FRANKLIN Johnson</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 9 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 23, 1908</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u>		11. IF UNDER 24 HRS. Hours <u>16</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner &amp; Operator-Johnson Radio &amp; T.V.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sales &amp; Service</u>			
11. BIRTHPLACE (State or foreign country) <u>Nanticoke, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>William C. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u></u>			
17. INFORMANT <u>Mrs. Margaret A. Johnson (Wife)</u>				18. ADDRESS <u>Monticello &amp; Federal Sts. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>16 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> 19 p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1959</u> to <u>June 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 31 1960</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Gray</u>				22b. DATE SIGNED <u>January 9, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>				22d. ADDRESS <u>Camden Ave. Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 13 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

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1302  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1303

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1288

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>Rural Princess Anne 19X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Danah</u> First <u>JONES</u> Middle Last		4. DATE OF DEATH <u>JANUARY 18 1961</u> Month Day Year					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 27 1951</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Jones</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Peyton</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. John Widdowson</u> Address <u>Mt Vernon Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Branch Pneumonia</u> DUE TO (b) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> 19 <u>60</u> to <u>1/15</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>61</u> , and that death occurred at <u>11</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Fred R. Grimes</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		23d. LOCATION (City, town, or county) (State) <u>Mt Vernon Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Herman Prince</u>				ADDRESS <u>Princess Anne Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>			

1303

CERTIFICATE OF DEATH

THE HAWAIIAN BUREAU OF HEALTH

OFFICE OF THE REGISTRAR

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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
SM 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
1304 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>P.G. Hospt.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>220 Newton Street.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Dennis Mark Jones</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>61.</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>P.G. Hospt. Salisbury, Md. U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Vivian Mumford Jones</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mrs. Vivian Mumford Jones (Mother)</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Earl L. Royer</b>			EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REBURY (Specify)			22b. DATE THEREOF <b>Jan. 31.61.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery,</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury. Maryland.</b>					
23. FUNERAL DIRECTOR <b>Holloway &amp; Co. Salisbury, Maryland</b>						24a. REC'D BY REGISTRAR <b>JAN 31 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

2082354XV5

THE STATE  
OF NEW YORK

1308

1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
IN THE COUNTY OF NEW YORK

300 Madison Street

1. Name of Deceased

2. Age

3. Sex

4. Occupation

5. Cause of Death

6. Date of Death

7. Place of Death

8. Signature of Examiner

9. Signature of Physician

10. Signature of Coroner

11. Signature of Registrar

12. Signature of Clerk

13. Signature of Justice

14. Signature of Sheriff

15. Signature of Constable

16. Signature of Watchman

17. Signature of Night Watchman

18. Signature of Patrolman



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1305

## CERTIFICATE OF DEATH

Reg. Dist. No.

61290

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>400 Woodcrest Ave.</b>				d. STREET ADDRESS <b>400 Woodcrest Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank A. Keller</b>				4. DATE OF DEATH Month Day Year <b>January 2, 1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 13, 1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shop Maintenance</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State Rds. Comm</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Benjamin Keller</b>				14. MOTHER'S MAIDEN NAME <b>Maria Plantz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>400 Woodcrest Ave.</b> <b>Miss Radella Keller Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma</b> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>50</b> , to <b>1/2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1/2</b> , 19 <b>61</b> , and that death occurred at <b>9:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>H. R. Granne</b> M.D. <b>Salisbury, Md.</b> PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, or other disposition (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1303

CERTIFICATE OF DEATH

State of Maryland, Baltimore, City

That on the 10th day of January, 1900, at Baltimore, Maryland, died

John A. Smith, aged 45 years, of the County of Baltimore, State of Maryland.

Caused by

Consumption of the lungs.

Witness my hand and the seal of the City of Baltimore, this 10th day of January, 1900.

Mayor of Baltimore

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

John A. Smith

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1306

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1291

1. PLACE OF DEATH a. COUNTY <u>WILCOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WILCOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRUITLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1 MEADOW BRIDGE RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE BUTZ KEMMERER</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 23 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 31, 1904</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CLAYTON J. KEMMERER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA BUTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>162-09-1208</u>		17. INFORMANT Address <u>Mrs. Florence L. Kemmerer, Same.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with left</u> <u>420.1</u> DUE TO <u>hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Posterior Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Cardiovascular Dis</u> (c) <u>(?)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>Jan 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 23, 1961</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Refus S. Gardner Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>REFUS S. GARDNER JR.</u>				22d. ADDRESS <u>PINE BLUFF RD, SALISBURY, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-27-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Ambleton Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill + Johnson Co. Salisbury, Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

STATE OF NEW YORK  
IN SENATE  
January 10, 1906

1306

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 10, 1906

ALBANY:  
J. B. LIPPINCOTT & CO., PRINTERS  
1906

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

61292

Reg. Dist. No. ....

1307

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Rural - Mardela Springs</u>		LENGTH OF STAY (in this place) <u>1 mo.</u>		CITY OR TOWN <u>Rural - Mardela Springs</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Shade Convalescent Home</u>				STREET ADDRESS <u>Bridge St.</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Anna T Larrimore</u>				<b>4. DATE OF DEATH</b> (Month) <u>Jan.</u> (Day) <u>28</u> (Year) <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>27 June 1891</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John F Cheezum</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Mary East 540 Nylon Blvd. Seaford - Del.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
443 IMMEDIATE CAUSE (A) <u>Cerebro-vascular Hemorrhage, left</u>				INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>				<u>5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis, generalized</u>				<u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes</u>				<u>5 yrs</u>			
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>60</u> , to <u>Jan</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>28 Jan</u> , 19 <u>61</u> , and that death occurred at <u>10:45</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Mary G. Larrimore</u>				ADDRESS (Street, city, town, state) <u>Box 262 - Mardela, Md</u> DATE SIGNED <u>28 Jan 61</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/31/61</u>		NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>		LOCATION (City, town, or county) <u>Mardela, Maryland</u> (State) _____	
24. REC'D BY REGISTRAR <u>FEB 1 '61</u>		REGISTRAR'S SIGNATURE <u>C. S. S. K. K.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>		ADDRESS <u>Shanptown, Md</u>	





TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1308

Item 9 Film 6279 1-30-61 et

1293

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b> c. LENGTH OF STAY IN 1b <b>8 Yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Main St.,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b> d. STREET ADDRESS <b>1 Main St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GUY</b> Middle <b>ELDRIDGE</b> Last <b>LONG</b>		4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1883</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b>	11. IF UNDER 24 HRS. Days <b>11</b> Hours <b>11</b> Min. <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Long</b>		14. MOTHER'S MAIDEN NAME <b>Cora Disharoon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-6959</b>	
17. INFORMANT <b>Mrs. G.E. Long, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Coronary Occlusion</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b> <b>7 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/4</b> 19 <b>61</b> to <b>1/14</b> 19 <b>61</b> , that (I) (we) lost saw the deceased alive on <b>1/14</b> 19 <b>61</b> , and that death occurred at <b>7:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Fred R. Gramse</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b>		22b. DATE SIGNED <b>1/16/1961</b> 22d. ADDRESS <b>South Division St., Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/17/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 19 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

*Norman T. Baker*

1308

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

1309

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01294

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.D.# 4 Johnson Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>WAYNE</u> Last <u>Messick</u>		4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1954</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Boy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Arthur Amoss Messick</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Mary Tawes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Arthur A. Messick (Father)</u>		18. ADDRESS <u>R.D.#4 Johnson Rd Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> DUE TO <u>782.9</u> (b) <u>(Extreme Hyperpyrexia (Temp 108))</u> DUE TO <u>(? Sepsis)</u> (c) <u>(? Abnormality of Temperature Regulation)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital Cerebral Defect - Convulsive Disorder</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> p. m. <u>N/A</u> 19 <u>61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> 19 <u>61</u> to <u>1/19</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/19</u> 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred C Kolls</u>		22b. DATE SIGNED <u>Jan. 19, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Kolls</u>		22d. ADDRESS <u>Medical Center, Salisbury Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 21, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WICOMICO MEMORIAL PARK</u>		23d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
ADDRESS <u>SALISBURY MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>JAN 23 '61</u>			

1369

CERTIFICATE OF DEATH

Volume 13

1910

General Central Dpt - (Cavalry Division)  
(Foster, Hypertension (Comp. 18))  
Foster, Hypertension (Comp. 18)

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1310

1295

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>221 West Philadelphia Ave</b>		d. STREET ADDRESS <b>221 W. Philadelphia Ave</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JEROME</b> Middle <b>RUFUS</b> Last <b>MILES</b>		<b>4. DATE OF DEATH</b> Month <b>JANUARY</b> Day <b>14th</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 26, 1888</b>
<b>9. AGE</b> (In years last birthday) <b>72 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>72</b> Days <b>14</b> Hours <b>14</b> Min.	<b>11. IF UNDER 24 HRS.</b> Months <b>72</b> Days <b>14</b> Hours <b>14</b> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Baker at Baking Co.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Baker</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Somerset Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Samuel Miles</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Hattie - - - - -</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Mrs. Katie Miles (Wife)</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Advanced Generalized Cerebral Palsy</b> DUE TO <b>1 1/2 yrs.</b> (c) <b>1 1/2 yrs.</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>N/A</b>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		<b>20f. (City or town)</b> (County) (State) <b>N/A</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5:15 P.M.</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>William H. Fisher</b> M.D.		<b>22b. DATE SIGNED</b> <b>Jan. 18 / 1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. William H. Fisher</b>		<b>22d. ADDRESS</b> <b>Nedical Center Salisbury, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Jan. 18, 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>PARSONS CEMETERY</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>SALISBURY, MARYLAND</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>		<b>25. REC'D BY REGISTRAR</b> <b>DATE JAN 19 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kneass</b>			





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1311

61296

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deers Head Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ida Nelson Milligan</b>		4. DATE OF DEATH Month Day Year <b>Jan. 14 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1863</b>
9. AGE (In years last birthday) <b>97</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel J. Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bozman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Kathryn Milligan</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 da</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-17-1961</b> to <b>1-14-1961</b> , that (I) (we) last saw the deceased alive on <b>1-14-1961</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b>		22b. DATE SIGNED <b>1-14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry</b>		22d. ADDRESS <b>Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Levin P. Wilson</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 19 '61</b>	
ADDRESS <b>Princess Anne, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 7 Film G281 2-15-61 et

61297

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>102 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b> d. STREET ADDRESS <b>501 Cedar Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Steven Mitchell</b>			4. DATE OF DEATH Month Day Year <b>Jan. 27 19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1887</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail carrier</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Alfred Mitchell</b>			14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Smith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Alice Vincent</b>			Address <b>Pocomoke City, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis, general</b> (a), stating the underlying cause last. (c)					INTERVAL BETWEEN CAUSE AND DEATH <b>10 yrs</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 17, 1960</b> to <b>Jan. 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan. 26, 1961</b> , and that death occurred at <b>3:35 A.M.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Lee L. Lawry</b> M.D.			22b. DATE SIGNED <b>1/27/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M.D.</b>			22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 31, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Modest Town</b>	23d. LOCATION (City, town or county) <b>Modest Town</b>	(State) <b>Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Johnson Funeral Home</b>			25a. REC'D BY REGISTRAR <b>FEB 2 '61</b>		
ADDRESS <b>Partly self va.</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1298

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>56 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ocean City Blvd.,</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CALVIN DURAND MORRIS</b>		4. DATE OF DEATH <b>1 21 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1869</b>
9. AGE (In years lost birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Truck</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William R. Morris</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Maddox, <del>SADIE</del></b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Linwood Morris, Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> DUE TO <b>Coronary</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Senility</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> to <b>1-21</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1-21</b> , 19 <b>61</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Andrew C. Mitchell</b>		22b. DATE SIGNED <b>1/23/1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>		22d. ADDRESS <b>Maryland Ave., Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 26 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

UNITED STATES DEPARTMENT OF HEALTH

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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1315  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

61300

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEER HEAD STATE HOSP.</u>		d. STREET ADDRESS <u>UNKNOWN</u> <u>3V01-4</u>	
3. NAME OF DECEASED (Type or print) First <u>Sidney J.</u> Middle <u>Norris</u> Last <u>Norris</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG-19-1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN NORRIS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH WITHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-09-6531</u>	
17. INFORMANT <u>DEER HEAD HOSPITAL RECORDS MD</u>		Address <u>SALISBURY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis 10 yrs</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 8, 1960</u> to <u>JAN 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 14, 1961</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>L. S. Lawrence</u>		22b. DATE SIGNED <u>1-14-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. S. Lawrence</u>		22d. ADDRESS <u>SALISBURY - MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-17-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S HUNTINGDON</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u>		24a. REC'D BY REGISTRAR <u>19 '61</u>	
ADDRESS <u>Primer Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1314

## CERTIFICATE OF DEATH

Reg. Dist. No. 1299

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Sanitarium</b>				d. STREET ADDRESS <b>RFD</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Watters</b> Last <b>Morrison</b>				4. DATE OF DEATH Month <b>1-8-61</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/6/77</b>	
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William J. H. Watters</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Nicodemus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Gerald A. Lee, RFD, Marion Station, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular renal disease</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury</b>				20g. (County) <b>Somerset</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>1-30</b> , 19 <b>58</b> , to <b>1-8</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1-4</b> , 19 <b>61</b> , and that death occurred at <b>9:40 A.M.</b> the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>116 East Main St., Salisbury, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Philip A. Insley</b> M.D.				PHYSICIAN'S NAME (Type) <b>Philip A. Insley. M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/10/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons</b>				ADDRESS <b>Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1316 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1301

1. PLACE OF DEATH e. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. Pen Gen Hospital</b>			d. STREET ADDRESS <b>625 Fitzwater St</b>		
4. DATE OF DEATH Month <b>JANUARY</b> Day <b>1st</b> Year <b>1961</b>			a. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ALINE</b> Middle <b>LAURA</b> Last <b>PATRICK</b>					
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Oct. 15, 1928</b>		
9. AGE (In years last birthday) <b>32 yrs.</b>			IF UNDER 1 YEAR Months <b>32</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work &amp; Hospital Attendant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Salisbury, Maryland</b>		
11. BIRTHPLACE (State or foreign country) <b>U S A</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>George W. Truitt</b>			14. MOTHER'S MAIDEN NAME <b>Laura B. Smith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Mrs. Laura B. Truitt (Mother) 625 Fitzwater St. Salisbury, Maryland</b>		
17. INFORMANT <b>Mrs. Laura B. Truitt (Mother) 625 Fitzwater St. Salisbury, Maryland</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet wound of Brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>976X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 minutes</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>shot self</b>		
20c. TIME OF INJURY Month, Day, Year <b>1:00 a.m. 1/1 1961</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>At Home</b>			20f. (City or town) (County) (State) <b>Salisbury (Wicomico) Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Jan. 3rd /1961</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Jan. 4, 1961</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>			22d. LOCATION (City, town, or country) (State) <b>Salisbury, Maryland</b>		
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>			24a. REC'D BY REGISTRAR <b>JAN 5 '61</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>					



FOR STATE  
DEPT. OF HEALTH

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DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CITY OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1317 Item 7 Film 4279 1-16-61 et											
1302											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. LENGTH OF STAY IN 1b <b>141 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>					
d. STREET ADDRESS <b>605 Dover Road</b>						f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Bessie Perkins</b>						4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-25-</b>		9. AGE (In years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Convalescent Home Nurse Aid</b>						11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>					
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>											
13. FATHER'S NAME <b>James Green</b>						14. MOTHER'S MAIDEN NAME <b>Nannie Bailey</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>						16. SOCIAL SECURITY NO. <b>—</b>					
17. INFORMANT <b>Catherine Smith, Easton, Md.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial infarction</b> (a), stating the underlying cause last. (c) <b>Severe Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>recent</b> <b>?</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 15, 1960</b> to <b>Jan. 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan. 3, 1961</b> , and that death occurred at <b>1:40 P.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>V. Juerman</b>						22b. DATE SIGNED <b>1/3/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>						22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>						23b. DATE THEREOF <b>1-7-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Richards Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Easton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Schell, Easton, Md.</b>						25a. REC'D BY REGISTRAR <b>Jan 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Catherine L. Knead</b>			

FILE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>6 Wks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>WALTER</b> Last <b>PHILLIPS</b>		4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>31</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>1</b> Days <b>31</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David I Webster</b>		14. MOTHER'S MAIDEN NAME <b>Emma Graham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-09-2164</b>	
17. INFORMANT <b>Mr. William Walter, Hebron</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>CARCINOMATOSIS (SITE UN-DETERMINED)</b> DUE TO (c) <b>DETERMINED</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>9 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>1/10</b> 19 <b>61</b> , to <b>1/31</b> 19 <b>61</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>1/31</b> 19 <b>61</b> , and that death occurred at <b>3A</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>John M. Bloxom III</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-2-1961</b>	
23a. PHYSICIAN'S NAME (Type) <b>JOHN M. BLOXOM III</b>		23b. ADDRESS <b>MEDICAL CENTER, SALISBURY, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2- -1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hebron, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

61304

1319

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELA</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GEORGETOWN</u> 46x3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>5 N. RACE ST</u>			
3. NAME OF DECEASED (Type or print) <u>ALEINE HILYARD ROYAL</u>				4. DATE OF DEATH <u>JANUARY 4 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Mar 98 62</u> yrs.	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>DELA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter B. Hilyard</u>				14. MOTHER'S MAIDEN NAME <u>Cora Toulson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>			
17. INFORMANT <u>Thayer L. Royal</u>				Address <u>GEORGETOWN DELA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic nephropathy</u> 2.60 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anasarca due to (1) kidney failure (2) heart failure</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years, 7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - advanced arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1960</u> to <u>Jan 4 1961</u> , that (I) <del>was</del> last saw the deceased alive on <u>4 Jan 1961</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>Joseph C. Fitzgerald</u>				22d. ADDRESS <u>707 Camden Avenue</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7 JAN 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST Pauls</u>	23d. LOCATION (City, town, or county) <u>GEORGETOWN DELA.</u> (State) _____				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald F Dard</u> ADDRESS <u>GEORGETOWN, DELA.</u>				25a. REC'D BY REGISTRAR <u>Jan 9 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1910

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of physician: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1305											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>24R 5 mos</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deers Head State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Queen Anne</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Centerville</b> d. STREET ADDRESS <b>Route # 3</b>					
3. NAME OF DECEASED (Type or print) <b>Eugene W Scott</b>						4. DATE OF DEATH <b>1-13-61</b> 19 Month Day Year					
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 15, 1929</b>		9. AGE (In years last birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>1 13 61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL SCOTT</b>						14. MOTHER'S MAIDEN NAME <b>Annie Scott</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>				16. SOCIAL SECURITY NO. <b>220-267066</b>		17. INFORMANT <b>Jane Scott, Queenstown, Md.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.1</b> DUE TO <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Quadraplegic- Fracture C-5 and C-6 with cord injury.</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Thrown by hay loader on Clark Farm.</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Aug. 12, 1958</b>				20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> <b>Farm.</b>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Centerville Queen Anne Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer</b> EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b> <b>407 Camden Ave, Salisbury, Md.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1-16-61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1-17-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CARMichael Cem</b>				22d. LOCATION (City, town, or country) (State) <b>Queenstown, Md.</b>	
23. FUNERAL DIRECTOR <b>James D. O'Neill, Boston, Md.</b> ADDRESS						24a. REC'D BY REGISTRAR <b>Jan 18 '61</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>M</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.A. Pen Gen Hospital</u>												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mass.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salt Framingham</u> d. STREET ADDRESS <u>Edgell Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>VINCENT SELLEW</u>						4. DATE OF DEATH Month Day Year <u>JANUARY 4th 1961</u>																	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>DIVORCED</u> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1913</u>		9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber (Self-employed)</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Voskotoja-Albania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>											
13. FATHER'S NAME <u>Louis Chkliwe</u>						14. MOTHER'S MAIDEN NAME <u>Lenora Kristo</u>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mr. Arthur Sellow (Son) 7A Pusan Road Framingham, Mass.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage mid brain spontaneous</u> <u>331X</u> DUE TO (b) <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH <u>year</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u> EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury, Md</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Jan. 5 / 1961</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 9, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dell Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Natick, Mass.</u>																	
23. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 6 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Royer</u>															

THE  
UNITED STATES  
DEPARTMENT OF  
HEALTH

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CERTIFICATE OF DEATH

Reg. Dist. No.

01307

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula Gen. Hospital</b>		d. STREET ADDRESS <b>Elizabeth</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>Beaven</b> Last <b>Sherwood</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>14th</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Sherwood</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Fleetwood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>716-01-9444</b>	
17. INFORMANT <b>Ethel Sherwood, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion, acute</b> <b>420.1</b> DUE TO <b>Coronary arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus - small laceration occiput.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>Jan 14</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 13</b> , 19 <b>61</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>303 East Street, Delmar Md.</b> DATE SIGNED <b>1-17-61</b> ACTUAL SIGNATURE <b>Dr. L.V. Sohler</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-18-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Gamel Co. - Delmar, Del.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1337

PLACE TO DEATH		MANNER OF DEATH	
HOSPITAL		NATURAL	
DATE OF DEATH		PLACE OF DEATH	
JAN 10 1918		BALTIMORE	
AGE		SEX	
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RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		RELIGION	
FARMER		METHODIST	
PREVIOUS ILLNESS		CAUSE OF DEATH	
NONE		HEART DISEASE	
IMMEDIATE CAUSE		MEDICAL ATTENDANCE	
HEART DISEASE		YES	
DATE OF EXAMINATION		SIGNATURE OF PHYSICIAN	
JAN 10 1918		[Signature]	
DATE OF REPORT		SIGNATURE OF REGISTRAR	
JAN 10 1918		[Signature]	

1. This certificate is to be filled out by the physician attending the patient at the time of death, or by the medical examiner if the death is sudden and unexpected, or by the coroner if the death is suspicious. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer.

2. The certificate is to be filled out in duplicate, one copy to be retained in the office of the Registrar, and the other copy to be sent to the local health officer.

3. The certificate is to be filled out in English, and the name of the deceased is to be written in full.

4. The date of death is to be written in full, and the place of death is to be written in full.

5. The age, sex, race, education, occupation, and religion of the deceased are to be written in full.

6. The previous illness, immediate cause of death, and medical attendance are to be written in full.

7. The date of examination and signature of physician are to be written in full.

8. The date of report and signature of registrar are to be written in full.

9. The certificate is to be filled out by the physician attending the patient at the time of death, or by the medical examiner if the death is sudden and unexpected, or by the coroner if the death is suspicious.

10. The certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer.



**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61308

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN IB <b>00A</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Otto H Short</b>		4. DATE OF DEATH <b>1-2-61</b>		Month <b>1</b> Day <b>2</b> Year <b>19</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 15, 1899</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming &amp; Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming &amp; Painter</b>		11. BIRTHPLACE (State or foreign country) <b>Del.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>James M. Short</b>		14. MOTHER'S MAIDEN NAME <b>Eslety a. West</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Grace Short - Pittsville, Md.</b>		17. INFORMATION <b>Address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Sudden</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-3-61</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/5/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>	
22d. LOCATION (City, town, or country) (State) <b>Pittsville Md.</b>					
23. FUNERAL DIRECTOR <b>Donald James Millatow, Del.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Howard</b>	

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JANUARY 1911

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 61309									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fitzwater St.</b>					d. STREET ADDRESS <b>Fitzwater St.</b>				
3. NAME OF DECEASED (Type or print) <b>Emma Jean Smith</b>					4. DATE OF DEATH <b>1-3-61</b>				
5. SEX <b>F</b>					6. COLOR OR RACE <b>C</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>12-30-60</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>				
11. BIRTHPLACE (State or foreign country) <b>Wicimico co.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				
13. FATHER'S NAME <b>Robert Smith</b>					14. MOTHER'S MAIDEN NAME <b>Emma Evans</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>*****P*****</b>				
17. INFORMANT <b>Emma Smith Salisbury, Md.</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia-</b>									
DUE TO (b) <b>491X</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <b>1-5-61</b>									
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>									
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
22b. DATE THEREOF <b>I-6-61</b>									
22c. NAME OF CEMETERY OR CREMATORIUM <b>Houston cem.</b>									
22d. LOCATION (City, town, or country) (State) <b>Salisbury, Md.</b>									
23. FUNERAL DIRECTOR <b>Booker M. West Salisbury, Md.</b>									
ADDRESS									
24a. REC'D BY REGISTRAR <b>JAN 11 '61</b>									
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>									

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

61310

1325

Item 9 1-24-61 et

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanitarium</b>		d. STREET ADDRESS <b>604 Monroe St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>MAY</b> Last <b>STATON</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>15th</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1901</b>
9. AGE (In years last birthday) <b>59 1/2</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS. Months <b>1</b> Days <b>15</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Fruitland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel M. Banks</b>		14. MOTHER'S MAIDEN NAME <b>Emma Jane Richardson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. George E. Staton (Husband)</b> <b>604 Monroe St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>260 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Diabetes Mellitus</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-3-1955</b> to <b>1-15-1961</b> , that (I) (we) last saw the deceased alive on <b>1-13-1961</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Andrew C. Mitchell</b>		22b. DATE SIGNED <b>Jan. 16 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 18, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SALISBURY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>JAN 18 '61</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1326 CERTIFICATE OF DEATH 61311

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>901 S. Division St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MATTIE ELIZABETH STEVENS</b>		4. DATE OF DEATH Month Day Year <b>JAN. 1st 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1902</b>
9. AGE (In years lost birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee (Restaurant)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pittsville, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>L. Teagle Truitt</b>		14. MOTHER'S MAIDEN NAME <b>Emma C. Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Everett Stevens (Husband)</b>		Address <b>901 S. Division St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Destructive Pulmonary Emphysema</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>mitral stenosis</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>5+ yrs</b> <b>5+ yrs</b> <b>(?)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma - Myocardial Ischemia</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 <b></b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>N/A</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>56</b> to <b>1/1</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> 19 <b>60</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Rufus S. Gardner Jr.</b>		22b. DATE SIGNED <b>Jan. 3 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner Jr.</b> <b>Dr. Thomas C. Hill</b>		22d. ADDRESS <b>Pine Bluff Road - Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 3, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>		23d. LOCATION (City, town, or county) <b>Pittsville, Maryland</b> (State) <b></b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>JAN 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>5 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>		<u>2342-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>209 10TH STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ETTA</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 1, 1878</u>	
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WATSON</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA STEWART</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS A.T. KELLY, 209 10TH STREET, POCOMOKE CITY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; Arterial Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20</u> 19 <u>61</u> to <u>Jan 25</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 25</u> 19 <u>61</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED <u>1-26-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>				22d. ADDRESS <u>SALISBURY, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-27-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NELSON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>RURAL-POCOMOKE CITY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George H. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 30 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles S. Knapp</u>			

CERTIFICATE OF DEATH

1951

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01313									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>					c. LENGTH OF STAY IN 1b <b>Salisbury (Rural)</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D.# 1 (At Home on Farm)</b>					d. STREET ADDRESS <b>R.D.# 1</b>				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year	
<b>WILLIAM</b>		<b>EDWARD</b>		<b>TOWNSEND</b>		<b>JANUARY</b>		<b>2nd 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 1, 1900</b>		9. AGE (In years last birthday) <b>60</b>	
								IF UNDER 1 YEAR Months Days	
								IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (Gulf Oil Co) on Route</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Driver-Salesman</b>				
11. BIRTHPLACE (State or foreign country) <b>R.D.# Salisbury, Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				
13. FATHER'S NAME <b>Murray Edward Townsend</b>					14. MOTHER'S MAIDEN NAME <b>Alice A. Pusey</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>Mrs. Mamie P. Townsend (Wife) R.D.# 1 Salisbury, Maryland</b>				
17. INFORMANT <b>Mrs. Mamie P. Townsend (Wife) R.D.# 1 Salisbury, Maryland</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Cervical Spine</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>912.1</b> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Farm Tractor turned over, falling on driver</b>				
20c. TIME OF INJURY Month, Day, Year <b>6:00 P.M. 1/2 1961</b>					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>At Home on Farm R.D.#1 Salisbury (Wico) Md.</b>				
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>Jan. 3 /1961</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>Jan. /1961</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Fruitland Cemetery</b>					22d. LOCATION (City, town, or country) (State) <b>Fruitland, Maryland</b>				
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>					24a. REC'D BY REGISTRAR DATE <b>JAN 5 '61</b>				
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>				

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

LOCALITY: \_\_\_\_\_

DECEASED (name): \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

DATE OF BURIAL: \_\_\_\_\_

PLACE OF BURIAL: \_\_\_\_\_

NAME OF MINISTER: \_\_\_\_\_

NAME OF CLERGYMAN: \_\_\_\_\_

NAME OF FUNERAL HOME: \_\_\_\_\_

NAME OF CEMETERY: \_\_\_\_\_

NAME OF INTERVIEWER: \_\_\_\_\_

NAME OF WITNESS: \_\_\_\_\_

NAME OF DECEASED: \_\_\_\_\_

NAME OF DECEASED: \_\_\_\_\_

NAME OF DECEASED: \_\_\_\_\_



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for our files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1329 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>				c. LENGTH OF STAY IN 1b <u>Delmar</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Delmar Md</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cheryl Ann Tull</u>				4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-19-60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Purnell Wodson</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Tull</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>Mildred Tull 112 Chestnut St. Salisbury</u>			
17. INFORMANT <u>Mildred Tull 112 Chestnut St. Salisbury</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				DATE SIGNED <u>1-9-61</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>1/3/1961</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u>				22d. LOCATION (City, town, or country) (State) <u>Delmar Md.</u>			
23. FUNERAL DIRECTOR <u>Clinton S. Stewart</u>				24a. REC'D BY REGISTRAR <u>Salis, Md.</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>				DATE <u>JAN 12 '61</u>			

VS. A15ME  
5M 7/59

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1330

01315

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Salisbury,</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>4mo. 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton, Maryland</u> <u>05x -2</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>210 S. 3rd. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>W.</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1961</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-85</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Warren</u>			14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>217-28-4228</u>		17. INFORMANT <u>Hospital records</u>		Address <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. S. Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>A. S. General</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u> Years <u>  </u> Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> 19 <u>60</u> , to <u>Jan 22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 22</u> 19 <u>61</u> , and that death occurred at <u>4:25 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. Maldve</u>		M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Jan. 22, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>		22d. ADDRESS <u>Salisbury, Md.</u>					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 24, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bloomery</u>		23d. LOCATION (City, town, or county) (State) <u>Near Denton, Md.</u> <u>  </u> <u>  </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Vergel</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 25 61</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Date of Death	
Cause of Death		Manner of Death		Place of Death	
Physician's Signature		Medical Examiner's Signature		Registrar's Signature	
Date of Certificate		City		County	
State		Zip		Registration Number	

*[Faint handwritten notes and signatures at the bottom of the page]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1316

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>19X-1</u>	
3. NAME OF DECEASED (Type or print) <u>Roger</u> First <u>Barton</u> Middle <u>White</u> Last		4. DATE OF DEATH <u>January 6</u> 19 <u>61</u> Month Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1886</u> 74 yrs.
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Well Driller</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Daniel White</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Orra White</u> Address <u>Mt. Vernon, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> 19 <u>61</u> , to <u>Jan 6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 6</u> 19 <u>61</u> , and that death occurred at <u>12</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		22b. DATE SIGNED <u>1/6/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/8/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grace Episcopal</u>		23d. LOCATION (City, town, or county) (State) <u>Mt Vernon Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Hunn</u> ADDRESS <u>Princess Anne Md</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 13 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1931

(M)

Coronary Heart Disease  
Myocardial Infarction

Robert Green

Robert White

Robert White, Mt. Vernon, Md.

Robert White

Robert

Robert White

Robert White

Robert White

Robert White

Robert White

3

Robert White

Robert White

Robert C. White

Robert White

Robert



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1332

01317

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WINDMILL GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>LEE</u> Last <u>White</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR Months <u>69</u> Days <u>69</u> Hours <u>69</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Eden, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13. FATHER'S NAME <u>William Dykes</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Shockley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>N/A</u>			
17. INFORMANT <u>Mr. Martin White (Husband)</u> Address <u>1341 S. Division St. Salisbury, Maryland</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Origin undetermined (Microscopic examination)</u> DUE TO (c) <u>may reveal &amp; later</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> 19 <u>61</u> p. m. <u>N/A</u>			
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>			
20e. (City or town) <u>N/A</u> (County) <u>N/A</u> (State) <u>N/A</u>				21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>59</u> to <u>Jan 4</u> 19 <u>61</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>4 Jan</u> 19 <u>61</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph C. Fitzgerald</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 1/5/61				22b. DATE SIGNED <u>1/5/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph C. Fitzgerald</u>				22d. ADDRESS <u>707 Camden Ave. Salisbury Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 7, 1961</u>				23b. DATE THEREOF <u>Jan. 7, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>				23d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JAN 6 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				25c. DATE <u>JAN 6 '61</u>			

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61318

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>New Hope Road</b>		d. STREET ADDRESS <b>New Hope Road</b>	
3. NAME OF DECEASED (Type or print) <b>Louis Preston Wilkens</b>		4. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>61</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27-1910</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garage Att.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Wilkins</b>		14. MOTHER'S MAIDEN NAME <b>Manie Dishroon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>xx xxx</b>		16. SOCIAL SECURITY NO. <b>220-26-3516</b>	
17. INFORMANT <b>Lillian Carter Willards, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun wound of brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>9776X</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted single barrel shotgun wound of head.</b>	
20c. TIME OF INJURY Month, Day, Year <b>10 A.M. 1-2-61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Willards Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE WHEN MADE <b>Jan. 4, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Hope</b>		22d. LOCATION (City, town, or country) (State) <b>Willards, Md.</b>	
23. FUNERAL DIRECTOR <b>Peter Whaley Salisbury, Del.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 9 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>John S. Thomas</b>		24c. REGISTRAR'S SIGNATURE <b>John S. Thomas</b>	

100-100000  
100-100000

WILLIAM

New Hope Road

James Thompson

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James A. H.

James A. H.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1334

CERTIFICATE OF DEATH

1319

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>13 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> <b>12</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tony Tank Rd.,</b>				d. STREET ADDRESS <b>Tony Tank Rd.,</b>			
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>FRANKLYN</b> Last <b>WOODCOCK</b>				4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1891</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Broker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel P. Woodcock</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1</b>		17. INFORMANT <b>Mrs. S.F. Woodcock, Same</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Acute</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerotic Heart Disease</b> (c) <b>Myocardial insufficiency, Chronic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3+ yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/24</b> 19 <b>61</b> , to <b>1/18</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>61</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Rufus S. Gardner Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-20-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner</b>				22d. ADDRESS <b>Pine Bluff Rd., Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/20/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				ADDRESS <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 23 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

IN SENATE,  
January 10, 1881.

REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE,  
IN ANSWER TO A RESOLUTION PASSED  
BY THE SENATE, APRIL 18, 1880.

ALBANY:  
PUBLISHED BY THE STATE OF NEW YORK,  
1881.